



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-B536-01

MFDR Date Received

AUGUST 17, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Hospital does not have a negotiated contract with the Carrier. It is impossible to determine how the Carrier denied/reduced charge. ...Provider sent Carrier a Request for Reconsideration noting that Carrier failed to reimburse Provider pursuant to the appropriate sections of the fee guideline applicable when Provider does not request separate reimbursement for implantables, specifically 28 TEX. ADMIN. CODE section 134.403(f)(1). It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement, but because Provider did not request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A)."

Amount in Dispute: \$5,873.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute concerns reimbursement for DOS 8/18/2008. The provider is requesting the Carrier pay an additional \$5873.73. In reviewing the provider's request for additional reimbursement, it is entirely unclear how the Provider arrived at that number, except to double what the Carrier previously paid. Carrier has review this billing 3 -4 different times, and Carrier maintains its reimbursement in the amount of \$5873.73 is the correct amount and reflects the reimbursement owed pursuant to Rule 134.403(f)."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
Augut 18, 2008	Outpatient Hospital Services	\$5,873.73	\$5,873.73

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 11, 2008:

- 45 – The primary provider is a non-contracted provider.
- 58 – This service is not reimbursable in a hospital outpatient setting.
- 97 – This procedure has been included in another procedure performed on the same day.
- W1 – Review of this bill has resulted in an adjusted reimbursement of
- W1 – The reimbursement amount is based on the Medicare reimbursement plus the percentage increase specified by the state.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 58 – “This service is not reimbursable in a hospital outpatient setting.” The insurance carrier has not submitted any documentation to support their denial reason. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Per Medicare policy, procedure code A4649 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Per Medicare policy, procedure code A4649 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Procedure code 29888 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%.

This procedure is paid at 100%. This service is classified under APC 42, which, per OPSS Addendum A, has a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of \$1,709.38. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,873.89. If the total cost for a service exceeds 1.75 times the OPSS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of \$9,645.00 yields a cost of \$3,144.27. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for this service of \$2,873.89 divided by the sum of all APC payments is 76.06%. The sum of all packaged costs is \$16,493.80. The allocated portion of packaged costs is \$12,544.40. This amount added to the service cost yields a total cost of \$15,688.67. The cost of this service exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPSS payment is \$10,659.37. 50% of this amount is \$5,329.68. The total APC payment for this service, including outliers and any multiple procedure discount, is \$8,203.57. This amount multiplied by 200% yields a MAR of \$16,407.15.

- Per Medicare policy, procedure code 29876 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Procedure code 29881 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 41, which, per OPSS Addendum A, has a payment rate of \$1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,099.88. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of \$1,076.34. The non-labor related portion is 40% of the APC rate or \$733.25. The sum of the labor and non-labor related amounts is \$1,809.59. If the total cost for a service exceeds 1.75 times the OPSS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of \$0.00 yields a cost of \$0.00. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for this service of \$904.80 divided by the sum of all APC payments is 23.94%. The sum of all packaged costs is \$16,493.80. The allocated portion of packaged costs is \$3,949.40. This amount added to the service cost yields a total cost of \$3,949.40. The cost of this service exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPSS payment is \$2,366.00. 50% of this amount is \$1,183.00. The total APC payment for this service, including outliers and any multiple procedure discount, is \$2,087.80. This amount multiplied by 200% yields a MAR of \$4,175.60.
 - Per Medicare policy, procedure code 29882 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Per Medicare policy, procedure code 94762 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Per Medicare policy, procedure code 99205 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
 - Per Medicare policy, procedure code 99234 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
5. The total recommended payment for the services in dispute is \$20,582.74. This amount less the amount previously paid by the insurance carrier of \$5,873.73 leaves an amount due to the requestor of \$14,709.01. The requestor is seeking \$5,873.73. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$5,873.73.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$5,873.73, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	August 30, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.